Jefferson County Curbside Nutrition Program Registration Form

Date _____ First Name _____ Last Name _____ Middle Initial _____

Date of Birth _____ Age _____

Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone_____

Circle your responses:			
	Gender	Male | Female	**Living Alone?** Yes | No
	Marital Status	Single | Married | Widowed | Divorced | Life Partner | Other	
	Race	American Indian/Native Alaskan | Black/African American | Asian | Hispanic	
		Native Hawaiian/Pacific Islander | White (Non-Hispanic) | Other	
	Ethnicity	Hispanic or Latino | Not Hispanic or Latino	
	Income Status	If you are a **one-person** household, is your income: Above | Below **$1,073 per month?**	If there are **two people** in your household, is your income: Above | Below **$1,452 per month?**

NUTRITION CHECK: Put a check mark next to statements below that apply to you.

☐	I have an illness or condition that made me change the kind and/or amount of food eat.
☐	I eat fewer than 2 meals per day.
☐	I eat few fruits or vegetables or milk products.
☐	I have 3 or more drinks of beer, liquor or wine almost every day.
☐	I have tooth or mouth problems that make it hard for me to eat.
☐	I don't always have enough money to buy the food I need.
☐	I eat alone most of the time.
☐	I take 3 or more different prescribed or over-the-counter drugs a day.
☐	Without wanting to, I have lost or gained 10 pounds in the last 6 months.
☐	I am not always physically able to shop, cook and/or feed myself.

PLEASE TURN THIS PAGE OVER AND COMPLETE PAGE 2

ADL (Activities of Daily Living)

Place a check mark next to any activity that is difficult for you.
☐ Getting in and out of the bath or shower or preparing the bath, washing and drying
☐ Dressing and undressing
☐ Completing toilet activities and personal hygiene
☐ Getting in and out of bed or a chair
☐ Using utensils and eating without help
☐ Walking up and down a flight of stairs or walking without assistance

IADL (Instrumental Activities of Daily Living)

Place a check mark next to any activity that is difficult for you.
☐ Preparing your own meals
☐ Medication management
☐ Handling bill paying, banking, etc.
☐ Doing heavy housework and outside chores
☐ Doing light housework
☐ Shopping for personal items and/or groceries
☐ Traveling in a van, taxi, bus or car
☐ Answering the telephone or calling out on the telephone

Please provide the name of an Emergency Contact (available 10:30 AM - 1:00 PM):

Name _____ Relationship to you_____

Home Phone _____ Cell _____ Work Phone _____

PRIVACY STATEMENT

"The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions, please call the Aging & Disability Resource Center (ADRC) of Jefferson County at 920-674-8734."

ADRC Aging & Disability Resource Center of Jefferson County